STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING _____ B. WING _____	R-C 02/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	**5600 E 16TH ST INDIANAPOLIS, IN 46218**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00189842 completed on January 20, 2016. This visit was in conjunction with a PSR to the PSR completed on January 20, 2016, to the Recertification and State Licensure Survey completed on December 21, 2015. Complaint IN00189842 - Corrected Survey dates: February 22, 2016. Facility number: 000012 Provider number: 155029 AIM number: 100274900 Census and bed type: SNF/NF: 89 Total: 89 Census and Payor type: Medicare: 12 Medicaid: 53 Other: 24 Total: 89 Community Nursing Rehabilitation was found to be in compliance with 410 IAC 16.2-3.1 in regard to the PSR of the Investigation of Complaint # IN00189842. Quality review completed by 30576 on February 23, 2016.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE